

## **KENTUCKY EMPLOYEES' HEALTH PLAN PY 2011**

## **ENROLLMENT/CHANGE APPLICATION – Active Employee**

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Insurance Coordinator Section							
Date of Hire / /	Effective Date /	/ Company Number					
Reason for Application	If QE select reason Date	e of Event / /					
New Hire	Deletion of dependent	Addition of Dependent					
Open Enrollment	Divorce	Marriage					
New Group	Death	Birth/Adoption of child					
QE	Loss of eligibility	Guardianship/Ct Order					
Other	Gaining other coverage	Loss of other coverage					
Reason	Gaining Medicare/Medic	caid Loss of KCHIP/Medicaid					
	Other	Re-establishes eligibility					
	Reason	Special Enrollment					
Demographic Information							
☐ I am covered under a KY retirement plan ☐ Duty Plan ☐ Spouse's Hazardous ☐ Supplement ☐ I am a Dual Er							
Social Security Number	Name (First, MI, Last)	Date of Birth					
		Have you smoked					
Mailing Address		in the last 2 months?					
		Gender □ M □ F Marital Status □ M □S					
City, State, Zip Code							
Home or mobile phone number	Work phone number	Email Address					
Dependent Information							
SOCIAL SECURITY	NAME	BIRTH DATE CENTER Cross Reference Payment					
NUMBER	(FIRST, MI, LAST)	MONTH/ DAY/ YEAR GENDER Option (LRC, JRC not eligible)					
Spouse							
SP's Company number		spouse smoked in last 2 months  YES NO Date of hire/retirement /					
Child 1		/					
Child 2		/ / Male Natural Foster					
Child 2		Female Court Order Disabled    Disabled   Foster   Foster   Court Order   Foster   Foster   Court Order   Foster   Court Order   Foster   Foster					
Child 3		// Male Natural Foster Adopted Step Court Order Disabled					
Plan Election							
Benefit Options	Coverage Level	Healthcare FSA for qualified healthcare expenses Calendar Year Contribution must be divisible by two					
Commonwealth Optimum PPO	Single (self only)	min \$10/paycheck; max = \$5,000/year  Employee \$ Spouse \$					
Commonwealth Capitol Choice PPO	Parent Plus (self and child(ren))	If cross referenced					
Commonwealth Standard PPO	Couple (self and spouse)	Dependent Care FSA for qualified daycare expenses Calendar Year Contribution					
Commonwealth Maximum Choice PPO	Family (self, spouse and child(ren))	max = \$5,000; \$2,500 married filing separate  ☐ Single Married filing; ☐ Joint ☐ Separate					
☐ Waiver (No Health Insurance)	Employee \$ Spouse \$ If cross referenced						

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Dlar	Planholder's SSN									

## Authorization and Certification

## I understand and agree that:

- I have made the above plan selection for plan year 2011.
- My signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance (DEI), Kentucky Employees' Health Plan (KEHP) and any TPA's.
- If my spouse and I elect the <u>cross-reference payment option</u>, we are dual plan holders with Family coverage and that upon a loss of eligibility by either spouse, the remaining plan holder will have the option to enroll in either Single or Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/plan holder.
- I certify that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the Summary Plan Description(s) and in the KEHP Benefits Selection Guide. I understand that DEI requires supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan. And, in addition, an affidavit 2011 Certification of Dependent Eligibility must be submitted for dependent children between the ages of 19-26.
- All benefits for myself and eligible dependents be provided in accordance with the Summary Plan Description (s) and Benefits Selection Guide.
- I will abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- The elections indicated on this application may not be changed or cancelled during the Plan Year, with the exception of certain Qualifying Events.
- I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe. I authorize payment of my employee contributions to be made on a pre-tax basis unless I sign a Post-Tax Form.
- If I elect to waive KEHP medical coverage, with or without a stand-alone Health Reimbursement Account (HRA), I am doing so voluntarily and intentionally.
- Enrollment in a Healthcare and/or Dependent Care Flexible Spending Account (FSA) is voluntary and optional and that by completing the FSA
  section of this application, I am enrolling in an FSA, if eligible to participate.
- Regarding my FSA and HRA, any dependents for which I claim reimbursement are eligible to seek such reimbursement.
- I have a 90-day run-out period (until March 31) for reimbursement of eligible Healthcare FSA and HRA expenses incurred during my period of coverage.
- Regarding my Healthcare FSA, any unused amount remaining in my spending account at the end of the Plan Year cannot be carried forward to the next year due to federal law.
- My Humana*Access*SM Visa®Card will be suspended if the required HRA/ FSA claim verification is not sent in within sixty (60) days after the card swipe. I agree to follow all rules and guidelines established by the plan concerning the Humana*Access*SM Visa®Card.
- This Plan reserves the right to deny access to the card, require repayment, deduct/withhold from your paycheck and offset your HRA/ FSA if you fail to properly substantiate your HRA/ FSA claims.
- This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- Plan terms permit rescission of coverage with respect to an individual if the individual engages in an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact.
- I have rights under HIPAA and that DEI will comply with the HIPAA rules and that disclosure of protected information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to business associates, third party administrators, vendors, consultants, governmental agencies with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.
- Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing
  any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held
  responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting
  within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.
   Please submit this application to your Insurance Coordinator

Employee Signature	Date
Spouse Signature – REQUIRED if electing the cross-reference payment option	Date
Insurance Coordinator Signature	
Spouse's Insurance Coordinator Signature – REQUIRED if electing the cross-reference payment option	Date